San Mateo County Mental Health Services Division

THERAPEUTIC FEE ADJUSTMENT REQUEST – DEBT UNDER $50

CLIENT NAME ____________________________ MH #_____________________ DATE:______________

THERAPIST ______________________________ PROVIDER #___________________________________

CURRENT BALANCE $ ___________________ SCHEDULED CHARGE PER MONTH $ ___________

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1. I am requesting that this client's and/or family balance of $ __________ ☐ be deleted or ☐ reduced to $________________ for the following reason(s):

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2. I am requesting that this client's and /or family's charge on ______________________ in the amount of $____________ be ☐ deleted or ☐ reduced to $ _______________ for the following reason(s):

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SIGNATURE OF THERAPIST/UNIT CHIEF: ____

SIGNATURE OF ADMINISTRATIVE ASSISTANT: ____

* *

PROGRAM OFFICE USE ONLY: APROVED ☐ NOT APROVED ☐

COMMENT:____

MENTAL HEALTH DIRECTOR: _________________________________ DATE: ________________